AUTHORIZATION FOR DISCLOSURE/REQUEST OF PROTECTED HEALTH INFORMATION (PHI)

PHALCON LABEL

Name _____ CHR # ____

SSN _____ Race ____ DOB _____

Med# _____ Sex ____ Date _____

Address _____ Phone _____

I authorize the disclosure/request of the named individual's health information as described below. The following individual or organization is authorized to make the disclosure/request:

_____
Health Department

_____
Address

_____
City State Zip

This information may be disclosed to/requested from and used by the following individual organization:

_____
Name of Recipient (Provider)

_____
Address

_____
City State Zip

Additional Recipient (Provider): _____

_____

The type and amount of information to be disclosed/requested is as follows:

- ❑ Complete Medical Record
- ❑ History and Physical
- ❑ Lab Reports (Specify) _____
- ❑ X-Ray
- ❑ Medical Discharge Summary
- ❑ Nursing Summary
- ❑ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from date signed.

I understand that authorizing the disclosure/request of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure services/treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR Part 45 d 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information or to present my written revocation authorization I can contact:

_____

_____

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness

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Permission To Disclose Information For Social Services

I hereby give permission to the Alabama Department of Public Health to disclose information about me/this minor child to social service agencies, community agencies, and health care providers for the limited purpose of consultation or referral. This permission may include the disclosure of information about my/this child's medical condition but does not include the release of the written medical record.

I have been given an opportunity to discuss how this form will be used. I know that I have the right to revoke this permission at any time (except to the extent that action has already been taken). Unless otherwise revoked, this authorization will expire one year from the date signed.

_____ _____
Patient or Legal Representative Date

CHR 6A